

General Information for Authorization

Oct vices rollings	acon					1		1	
Org 1. 5	508					Serv	rice Type	2. SCAN	
				<u> </u>	Client lr	forma	tion		i .
Name 3. CLIENT			NT NAME			Clie	nt ID	4. 123456789WA	
Living Arra	ngements	5.				Refe	erence Auth#	6.	
					Provider	Inform	ation		
Requesting	NPI#	7. 1123456789				Req	uesting Fax#	8. XXXXXXXXX	
Servicing NPI # 9, 112.		9. 1123456	1123456789			Nam	ie	10. SERVICING PROVIDER NAME	
Referring NPI # 11.11		11. 1123450	5789			Refe	erring Fax #	12. XXXXXXXXX	
Service Start 13.		A. A		14. N/A		14. N/A			
				Se	rvice Requ	est in	ormation	I	
Description of service being requested: 15. PET-CT SCAN						16. I	N/A	17. N/A	
18. Serial /	NEA# N/A				·,	19. I	N/A		
20. Code 21. National 22. Mod Qualifier Code		i .	Units/Days 24. \$ Ame Requested Request			25. Part # (DME Only)		26. Tooth or Quad #	
C	CPT			N/A			N/A		N/A
P	P A9552			1 N/A				N/A	N/A
								•	
					M1!1 1		-41		
Diagnosis (^ode	27. IC	D 0	Diagnos	Medical I	28.	ation		·
Place of se		29.	<i>√</i> D -3	Diagnosi	3 Hallo	20.		•	
30. Comme		20.		.1.		1			

www.WaProviderOne.org

The material in this facsimile transmission is intended only for the use of the individual to who it is addressed and may contain information that is confidential, privileged, and exempt from disclosure under applicable law. <u>HIPAA Compliance</u>: Unless otherwise authorized in writing by the patient, protected health information will only be used to provide treatment, to see insurance payment, or to perform other specific health care operations.

Instructions to fill out the General Information for Authorization form, DSHS 13-835

FIELD	NAME	ACTIO	N ELDS MUST BE TYPED.		
	Org required		ne Number that Matches the Progra	am/Unit fo	or the Request
. 1		500 - D 501 - D 502 - D 509 - E 504 - H 505 - H 506 - In 507 - Ju 508 - M 510 - M 511 - O 513 - P 514 - A 515 - T	ivision of Alcohol and Substance A ental urable Medical Equipment (DME) conomic Services Administration (I ome Health ospice patient Hospital uvenile Rehabilitation Administration	buse (DA ESA) (DS n (JRA) (I	nsa)
	Service Type required		ne letter(s) in all CAPS that represe	ent the ser	vice type you are requesting
		AA	Ambulatory Aids	OS	Orthopedic Shoes
		BB	Bath Bench	OTC	Orthotics
	***************************************	ВЕМ	Bath Equipment (misc)	PAS	PAS
	navoranius	BGM	Blood Glucose Monitors	PDN	
		BGS	Bone Growth Stimulator	Private	Duty Nursing
		BP	Breast Pumps	PHY	Pharmacy
		BS	Bariatric surgery	PL	Patient Lifts
		BSS2	Bariatric surgery stage 2	PMR	PM and R
		C	Commode	PROS	Prosthetics
	Line	CI	Cochlear Implants	PRS	Prone Standers
		CIERP	Cochlear Implant Ext Repl Prts	PSY	Psychotherapy
		CSC	Commode/Shower Chair	PTL	Partial
		CWN	Crowns	PWH	Power Wheelchair - Home
		DASA	DASA	PWNF	
		DEN	Dentures	PWNF	
		EN	Enteral Nutrition	PHYS	Physician Services
2		ESA	ESA	R	Respiratory
2		FSFS	Floor Sitter/Feeder Seat	RBS	Rebases
		HB	Hospital Beds	RE	Room equipment
		HEA	Hearing Aids	RLNS	Relines
		HH	Home Health	RM	Readmission
		HSPC	Hospice	S SBS	Surgery
		ITA	Infusion/Parental Therapy	SC	Specialty Beds/Surfaces Shower chairs
		JRA	Inpatient admission - ITA JRA	SCAN	MRI/PET Scans
		LTAC	LTAC	SF	Standing Frames
		MC	Medication	SGD	Speech Generating Device
		MISC	Miscellaneous	SSIP	Short Stay (In-Patient)
		MN	Medical Nutrition	T	Therapies (PT/OT/ST)
		MWH	Manual Wheelchair - Home	TRN	Transportation
		MWNF	Manual Wheelchair - NF	TU	TENS Units
		0	Other	US	Urinary Supplies
		ODC	Orthodontic	V	Vision
		ODME	Other DME	VNSS	Vagus nerve stimulator surgery
		oos	Out of State	VOL	Inpatient admission-Voluntary
		OP	Ostomy Products	WDCS	· · · · · · · · · · · · · · · · · · ·

3	Name: Required.	Enter the last name, first name, and middle initial of the patient you are requesting authorization for.
	Client ID: Required.	Enter the client ID = 9 numbers followed by WA.
4		For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved – once the client ID is known – you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved.
5	Living Arrangements	Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc.
6	Reference Auth #	If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI #: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name	The name of the billing/servicing provider.
11	Referring NPI #	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #	The fax number of the referring provider.
13	Service Start Date	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T - CDT Proc Code C - CPT Proc Code D - DRG P - HCPCS Proc Code I - ICD-9/10 Proc Code R - Rev Code N - NDC-National Drug Code S - ICD-9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier	When appropriate enter a modifier.
. 23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific <u>Billing Instructions</u> and <u>fee schedules</u> for assistance) Must be entered in dollars & cents with a decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for all "By Report" codes requested.	Enter the manufacturer part # of the item requested.

26	Tooth or Quad#: Required for dental requests	Enter the tooth or quad number as listed below: QUAD 00 – full mouth 01 – upper arch 02 – lower arch 10 – upper right quadrant 20 – upper left quadrant 30 – lower left quadrant 40 – lower right quadrant Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
29	Place of Service	Enter the appropriate two digit place of service code.
30	Comments	Enter any free form information you deem necessary.

Field	Name	Action	
			S MUST BE TYPED
	Org required		mber that Matches the Program/Unit for the Request
			on of Alcohol and Substance Abuse (DASA)
		501 - Dental	•
			e Medical Equipment (DME)
			mic Services Administration (ESA) (DSHS)
		504 Home	•
	14	505—Hospic	
		506 - Inpatie	•
1			le Rehabilitation Administration (JRA) (DSHS)
		508 - Med	dical
		509 - Medie	cal Nutrition
		510 - Menta	al-Health
		511 Outpt	Proc/Diag
		_	al Medicine & Rehabilitation (PM & R)
	•		and Disability Services Administration (ADSA)
		515 - Transp	· · · · · · · · · · · · · · · · · · ·
	·	516 Miscel	
	Service Type required	Enter the lett	er(s) in all CAPS that represent the service type you are
		requesting.	
		1 0	
	•	AA	Ambulatory Aids
		BB	Bath Bench
	·	BEM	Bath-Equipment (mise)
		BGM	Blood Glucose Monitors
		BGS	Bone-Growth Stimulator
		BP	Breast Pumps
,		BS	Bariatric surgery
		BSS2	Bariatric surgery stage 2
		E	Commode
		CI	Cochlear Implants
		CIERP	Cochlear Implant Ext-Repl Prts
2		CSC	Commode/Shower Chair
		CWN	Crowns
		DASA	DASA
		DEN	Dentures
		EN	Enteral Nutrition
		ESA	ESA
		FSFS	Floor Sitter/Feeder Seat
		HB	Hospital-Beds
		HEA	Hearing Aids
		HH	Home Health
		HSPC	Hospice
		IPT	Infusion/Parental Therapy
		ITA	Inpatient admission - ITA
		JRA	JRA
		LTAC	LTAC

		•	
	•		
			•
Field	Name	Action	
		MC ·	Medication
		MISC	Miscellaneous
-		MN	Medical Nutrition
		MWH	Manual Wheelchair Home
	•	MWNF	Manual Wheelchair - NF
	•	θ	Other
	·	ODC	Orthodontie
	•	ODME	Other DME
		OOS	Out of State
		OP	Ostomy Products
		OS	Orthopedic Shoes
		OTC	Orthotics
		PAS	PAS
	•	PDN	Private Duty Nursing
		PHY	Pharmacy
		₽Ŀ	Patient Lifts
		PMR	PM and R
		PROS	Prosthetics
		PRS	Prone Standers
		PSY	Psychotherapy -
		PTL	Partial TV
		PWH	Power Wheelchair Home
		PWNF	Power Wheelchair NF
		PWNF	Power Wheelchair NF
		PHYS	Physician Services
	·	R DDC	Respiratory
		RBS	Rebases
		RE	Room equipment
		RLNS	Relines
		RM	Readmission
		\$	Surgery
		SBS SC	Specialty Beds/Surfaces Shower chairs
	,	1	
		SCAN	MRI/PET Scans
		SF	Standing Frames
		SGD	Speech Generating Device
		SSIP	Short Stay (In-Patient)
		Ŧ	Therapies (PT/OT/ST)
		TRN	Transportation
		TU	TENS Units
		US	Urinary Supplies
		¥ ,	Vision
		VNSS	Vagus nerve stimulator surgery
		AOF	Inpatient admission-Voluntary
		WDCS	Wound/decubiti care supplies
3	Name: Required.		st name, first name, and middle initial of the patient you
			ng authorization for.
4	Client ID: Required.	Enter the cl	ient ID = 9 numbers followed by WA.

Field	Name	Action
5	Living Arrangements	For Prior Authorization (PA) requests when the client ID is unknown (e.g. client eligibility pending): You will need to contact DSHS at 1-800-562-3022 and the appropriate extension of the Authorization Unit (See contact section for further instructions). A reference PA will be built with a placeholder client ID. If the PA is approved — once the client ID is known — you will need to contact DSHS either by fax or phone with the Client ID. The PA will be updated and you will be able to bill the services approved. Indicate where your patient resides such as, home, group home, assisted living, skilled nursing facility, etc. NOT REQUIRED FOR
6	Reference Auth #:	PET-CT SCANS If requesting a change or extension to an existing authorization, please indicate the number in this field.
7	Requesting NPI#: Required.	The 10 digit numeric number that has been assigned to the requesting provider by CMS.
8	Requesting Fax#:	The fax number of the requesting provider.
9	Servicing NPI #: Required.	The 10 digit numeric number that has been assigned to the billing/servicing provider by CMS.
10	Name:	The name of the billing/servicing provider.
11	Referring NPI #:	The 10 digit numeric number that has been assigned to the referring provider by CMS.
12	Referring Fax #:	The fax number of the referring provider.
13	Service Start Date:	The date the service is planned to be started if known.
15	Description of service being requested: Required.	A short description of the service you are requesting (examples, manual wheelchair, eyeglasses, hearing aid).
18	Serial/NEA#: Required for all DME repairs.	Enter the serial number of the equipment you are requesting repairs or modifications to or the NEA# to access the x-rays for this request.
· 20	Code Qualifier: Required.	Enter the letter corresponding to the code from below: T CDT Proc Code C - CPT Proc Code D DRG P HCPCS Proc Code I ICD 9/10 Proc Code R Rev Code N NDC National Drug Code S ICD 9/10 Diagnosis Code
21	National Code: Required.	Enter each service code of the item you are requesting authorization that correlates to the Code Qualifier entered.
22	Modifier:	When appropriate enter a modifier.
23	# Units/Days Requested: Required.	Enter the number of units or days being requested for items that have a set allowable. (Refer to the program specific <u>Billing Instructions</u> for the appropriate unit/day designation for the service code entered).
24	\$ Amount Requested: Required.	NOT REQUIRED FOR PET-CT SCANS Enter the dollar amount being requested for those service codes that do not have a set allowable. (Refer to the program specific Billing Instructions and fee schedules for assistance) Must be entered in dollars & cents with a

Field	Name	Action
		decimal (e.g. \$400 should be entered as 400.00.
25	Part # (DME only): Required for	NOT REQUIRED FOR PET-CT SCANS Enter the manufacture
23	all "By Report" codes requested.	part # of the item requested.
	Tooth or Quad#: Required for	NOT REQUIRED FOR PET-CT SCANS
	dental requests	Enter the tooth or quad number as listed below:
		QUAD
		00—full-mouth
		01—upper arch
26		02 lower arch
20		10 upper right quadrant
		20 upper left quadrant
		30 lower left quadrant
		40 lower right quadrant
		Tooth # 1-36, A-T, AS-TS, 51-82 and SN
27	Diagnosis Code:	Enter appropriate diagnosis code for condition.
28	Diagnosis name	Short description of the diagnosis.
20	Place of Service	Enter the appropriate two digit place of service code.
29		Use 11 for office; 22 for out-patient hospital
30	Comments:	Enter any free form information you deem necessary.